SOS APA Form 001

Mississippi Secretary of State
700 North Street P. O. Box 136, Jackson, MS 39205-0136

ADMINISTRATIVE PROCEDURES NOTICE FILING

AGENCY NAME	CONTACT PERSON	TELEPHONE NUMBER	
Division of Medicaid	Margaret Wilson	(601) 359-5248	
ADDRESS	CITY	STATE	ZIP
550 High Street, Suite 1000	Jackson	MS	39201
EMAIL: Margaret.Wilson@medicaid.ms.gov	SUBMIT DATE: MAY 0 6 2015	Name or number of rule(s): Title 23: Division of Medicaid; Part 207: Institutional Long Term Care; Chapter 2: Nursing Facility; Rules 2.7: Admission Requirements, 2.9: Resident Assessment-Minimum Data Set (MDS), 2.10: Case Mix Reimbursement, 2.15: Ventilator Dependent Care, 2.16: Therapy Services	

Short explanation of rule/amendment/repeal and reason(s) for proposing rule/amendment/repeal: This filing is to update the language to correspond with State Plan Amendment (SPA) 15-004 Nursing Facility Reimbursement. There were non-substantive changes made to rules 2.15: Ventilator Dependent Care and 2.16: Therapy Services.

Specific legal authority authorizing the promulgation of rule:
42 USC §§ 1395i-3,1396r; 42 CFR §§ 435.1010, 483.20, 483.75, 483.100-483.106, 483.112, 483.120, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

List all rules repealed, amended, or suspended by the proposed rule: Rules 2.7, 2.9, 2.10, 2.15, 2.16

ORAL PROCEEDING:

☐ An oral proceeding is scheduled for this rule on Date: _____ Time: _____ Place: _____

☒ Presently, an oral proceeding is not scheduled on this rule.

If an oral proceeding is not scheduled, an oral proceeding must be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) or more persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address, email address, and telephone number of the person(s) making the request; and, if you are an agent or attorney, the name, address, email address, and telephone number of the party or parties you represent. At any time within the twenty-five (25) day public comment period, written submissions including arguments, data, and views on the proposed rule/amendment/repeal may be submitted to the filing agency.

ECONOMIC IMPACT STATEMENT:

☐ Economic impact statement not required for this rule. ☒ Concise summary of economic impact statement attached.

TEMPORARY RULES	PROPOSED ACTION ON RULES	FINAL ACTION ON RULES
_____ Original filing	**Action proposed:**	**Date Proposed Rule Filed:** _____
_____ Renewal of effectiveness	____ New rule(s)	**Action taken:**
To be in effect in _____ days	__X__ Amendment to existing rule(s)	_____ Adopted with no changes in text
Effective date:	_____ Repeal of existing rule(s)	_____ Adopted with changes
_____ Immediately upon filing	_____ Adoption by reference	_____ Adopted by reference
_____ Other (specify): _____	**Proposed final effective date:**	_____ Withdrawn
	____ 30 days after filing	_____ Repeal adopted as proposed
	__X__ Other (specify): JUL 0 1 2015	**Effective date:**
		_____ 30 days after filing
		____ Other (specify): _____

Printed name and Title of person authorized to file rules: David J. Dzielak, Ph.D., Executive Director

Signature of person authorized to file rules: _____

DO NOT WRITE BELOW THIS LINE

OFFICIAL FILING STAMP	OFFICIAL FILING STAMP	OFFICIAL FILING STAMP
	FILED MAY 0 6 2015 MISSISSIPPI SECRETARY OF STATE	
Accepted for filing by	Accepted for filing by #21275	Accepted for filing by

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

DELBERT HOSEMANN
Secretary of State

CONCISE SUMMARY OF ECONOMIC IMPACT STATEMENT

An Economic Impact Statement is required for this proposed rule by Section 25-43-3.105 of the Administrative Procedures Act. This is a Concise Summary of the Economic Impact Statement which must be filed with the Secretary of State's Office.

AGENCY NAME	CONTACT PERSON		TELEPHONE NUMBER
Division of Medicaid	Margaret Wilson		601-359-5248
ADDRESS	CITY	STATE	ADDRESS
Walter Sillers Building, Suite 1000	Jackson	MS	Walter Sillers Building, Suite 1000
EMAIL	DESCRIPTIVE TITLE OF PROPOSED RULE		
Margaret.Wilson@medicaid.ms.gov	Title 23: Division of Medicaid; Part 207: Institutional Long Term Care; Chapter 2: Nursing Facility; Rules 2.7: Admission Requirements, 2.9: Resident Assessment-Minimum Data Set (MDS), 2.10: Case Mix Reimbursement, 2.15: Ventilator Dependent Care, 2.16: Therapy Services		

Specific Legal Authority Authorizing the promulgation of Rule:	*Reference to Rules repealed, amended or suspended by the Proposed Rule:*
42 USC §§ 1395i-3,1396r; 42 CFR §§ 435.1010, 483.20, 483.75, 483.100-483.106, 483.112, 483.120, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.	Rules 2.7, 2.9, 2.10, 2.15, 2.16

A. Estimated Costs and Benefits

1. Briefly summarize the benefits that may result from this regulation and who will benefit:
   This filing does not have an economic impact.
2. Briefly describe the need for the proposed rule:
   N/A
3. Briefly describe the effect the proposed action will have on the public health, safety, and welfare:
   N/A
4. Estimated Cost of implementing proposed action:
   a. To the agency
      ☒ Nothing ☐ Minimal ☐ Moderate ☐ Substantial ☐ Excessive
   b. To other state or local government entities
      ☒ Nothing ☐ Minimal ☐ Moderate ☐ Substantial ☐ Excessive
5. Estimated Cost and/or economic benefit to all persons directly affected by the proposed rule:
   a. Cost:
      ☒ Nothing ☐ Minimal ☐ Moderate ☐ Substantial ☐ Excessive
   b. Economic Benefit:
      ☒ Nothing ☐ Minimal ☐ Moderate ☐ Substantial ☐ Excessive
6. Estimated impact on small businesses:
   ☒ Nothing ☐ Minimal ☐ Moderate ☐ Substantial ☐ Excessive
   a. Estimate of the number of small businesses subject to the proposed regulation:
   b. Projected costs for small businesses to comply:
   c. Statement of probable effect on impacted small businesses:
7. The cost of adopting the rule compared to not adopting the rule or significantly amending the existing rule (check option): N/A

☐ the same as ☐ minimally more than ☐ moderately more than
☐ substantially more than ☐ excessively more than

8. The benefit of adopting the rule compared to not adopting the rule or significantly amending the existing rule (check option): N/A
   ☐ substantially less than ☐ moderately less than ☐ minimally less than
   ☐ the same as ☐ minimally more than ☐ moderately more than
   ☐ substantially more than ☐ excessively more than

B. Reasonable Alternative Methods

1. Other than adopting this rule, are there less costly or less intrusive methods for achieving the purpose of the proposed rule?
   ☐ yes ☒ no

2. If yes, please briefly describe available, reasonable alternative(s) and the reasons for rejecting those alternatives in favor of the proposed rule. (Please see §25-43-4.104 for factors you must consider.)

C. Data and Methodology

Please briefly describe the data and methodology you used in making the estimates required by this form.
N/A

D. Public Notice

Where, when, and how may someone present their views on the proposed rule and demand an oral proceeding on the proposed rule if one is not already provided?

Written comments will be received by the Division of Medicaid, Office of the Governor, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, MS 39201, thirty (30) days from the date of publication of public notice. All comments will be available for public review at the above address.

SIGNATURE	TITLE Executive Director
DATE 5/6/15	PROPOSED EFFECTIVE DATE OF RULE JUL 0 1 2015